Pre-Existing Condition Limitation means, with respect to coverage of a Covered Person who is age 19 or older, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the Enrollment Date, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before that date. Genetic information will not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to that information. Pregnancy will not be treated as a Pre-Existing Condition.

Prescription Drugs are drugs, biologicals and compound prescriptions which are sold only by prescription and which are required to show on the manufacturer's label the words: "Caution-Federal Law Prohibits Dispensing Without a Prescription" or other drugs and devices as determined by Horizon BCBSNJ, such as insulin.

Preventive Care means charges for routine physical examinations, including related laboratory tests and x-rays, immunizations and vaccines, well baby care, pap smears, mammography, screening tests, bone density tests, colorectal cancer screening, and Nicotine Dependence Treatment.

Private Duty Nursing means Skilled Nursing Care for Covered Persons who require individualized continuous Skilled Nursing Care provided by a registered nurse or a licensed practical nurse.

Prosthetic Appliance means any artificial device that is not surgically implanted that is used to replace a missing limb, appendage or any other external human body part including devices such as artificial limbs, hands, fingers, feet and toes, but excluding dental appliances and largely cosmetic devices such as artificial breasts, eyelashes, wigs and other devices which could not by their use have a significantly detrimental impact upon the musculoskeletal functions of the body.

Provider means a recognized Facility or Practitioner of health care in accordance with the terms of this Policy.

Public Health Plan means any plan established or maintained by a State, the U.S. government, a foreign country, or any political subdivision of a State, the U. S. government, or a foreign country that provides health coverage to individuals who are enrolled in the plan.

Referral means specific direction or instructions from a Covered Person's Primary Care Physician or care manager in conformance with Horizon BCBSNJ's policies and procedures that directs a Covered Person to a Facility or Practitioner for health care.

Rehabilitation Center means a Facility which mainly provides therapeutic and restorative services to Ill or Injured people. Horizon BCBSNJ will recognize it if it carries out its stated purpose under all relevant state and local laws, and it is either:

a) accredited for its stated purpose by either the Joint Commission or the Commission on Accreditation for Rehabilitation Facilities; or
b) approved for its stated purpose by Medicare.

In some places a Rehabilitation Center is called a "rehabilitation hospital."

Routine Foot Care means the cutting, debridement, trimming, reduction, removal or other care of corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, dystrophic nails, excrescences, helomas, hyperkeratosis, hypertrophic nails, non-infected ingrown nails, deratomas, keratosis, onychauxis, onychocryptosis tylomas or symptomatic complaints of the feet. Routine Foot Care also includes orthopedic shoes, and supportive devices for the foot.

Routine Nursing Care means the appropriate nursing care customarily furnished by a recognized Facility for the benefit of its Inpatients.

Schedule means the **Schedule of Insurance and Premium Rates** contained in this Policy.

Skilled Nursing Care means services which are more intensive than Custodial Care, are provided by a registered nurse or licensed practical nurse, and require the technical skills and professional training of a registered nurse or licensed practical nurse.

Skilled Nursing Facility (see Extended Care Center.)

Small Employer means, in connection with a Group Health Plan with respect to a Calendar Year and a Plan Year, any person, firm, corporation, partnership, or political subdivision that is actively engaged in business that employed an average of at least two but not more than 50 eligible Employees on business days during the preceding Calendar Year and who employs at least two eligible Employees on the first day of the Plan Year, and the majority of the eligible Employees are employed in New Jersey. All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as one employer. In the case of an employer that was not in existence during the preceding Calendar Year, the determination of whether the employer is a small or large employer shall be based on the average number of eligible Employees that it is expected that the employer will employ on business days in the current Calendar Year.

Special Care Unit means a part of a Hospital set up for very ill patients who must be observed constantly. The unit must have a specially trained staff. And it must have special equipment and supplies on hand at all times. Some types of Special Care Units are:
a) intensive care units;
b) .cardiac care units;
c) neonatal care units; and
d) burn units.

Substance Abuse means abuse of or addiction to drugs or alcohol.

Substance Abuse Centers are Facilities that mainly provide treatment for people with substance abuse problems. Horizon BCBSNJ will recognize such a place if it carries out its stated purpose under all relevant state and local laws, and it is either:
a) ccredited for its stated purpose by the Joint Commission; or
b) approved for its stated purpose by Medicare.

Supplemental Limited Benefit Insurance means insurance that is provided in addition to a Health Benefits Plan on an indemnity non-expense incurred basis.

Surgery means:
a) the performance of generally accepted operative and cutting procedures, including surgical diagnostic procedures, specialized instrumentations, endoscopic examinations, and other invasive procedures;
b) the correction of fractures and dislocations;
c) reasonable and customary preoperative and post-operative care; or
d) any of the procedures designated by Current Procedural Terminology codes as Surgery.

Therapeutic Manipulation means the treatment of the articulations of the spine and musculoskeletal structures for the purpose of relieving certain abnormal clinical conditions resulting from the

impingement upon associated nerves causing discomfort. Some examples are manipulation or adjustment of the spine, hot or cold packs, electrical muscle stimulation, diathermy, skeletal adjustments, massage, adjunctive, ultra-sound, doppler, whirlpool, hydro therapy or other treatment of similar nature.

Total Disability or Totally Disabled means, except as otherwise specified in this Policy, that an Employee who, due to Illness or Injury, cannot perform any duty of his or her occupation or any occupation for which he or she is, or may be, suited by education, training and experience, and is not, in fact, engaged in any occupation for wage or profit. A Dependent is totally disabled if he or she cannot engage in the normal activities of a person in good health and of like age and sex. The Employee or Dependent must be under the regular care of a Practitioner.

Urgent Care means care for a non-life threatening condition that requires care by a Provider within 24 hours.

Waiting Period means, with respect to a Group Health Plan and an individual who is a potential participant or beneficiary in the Group Health Plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the Group Health Plan.

We, Us, Our means Horizon BCBSNJ.

You, Your and Yours mean the Employer.

EMPLOYEE COVERAGE

Eligible Employees

Subject to the **Conditions of Eligibility** set forth below, and to all of the other conditions of this Policy, all of the Policyholder's Employees who are in an eligible class will be eligible if

a) the Employees are Actively at Work Full-Time Employees

In certain situations, the Actively at Work requirement will not apply. If an Employee is not Actively at Work due to a Health Status-Related Factor, the Employee will nevertheless be considered an Eligible Employee. In addition, refer to the Exception below.

For purposes of this Policy, Horizon BCBSNJ will treat partners, proprietors and independent contractors like Employees if they meet this Policy's **Conditions of Eligibility.**

Conditions of Eligibility

Full-Time Requirement
Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, Horizon BCBSNJ will not insure an Employee unless the Employee is an Actively at Work a Full-Time Employee.

Enrollment Requirement
Horizon BCBSNJ will not insure the Employee until the Employee enrolls and agrees to make the required payments, if any. If the Employee does this within 30 days of the Employee's Eligibility Date, coverage is scheduled to start on the Employee's Eligibility Date.

If the Employee enrolls and agrees to make the required payments, if any:
a) more than 30 days after the Employee's Eligibility Date; or
b) after the Employee previously had coverage which ended because the Employee failed to make a required payment.

Horizon BCBSNJ will consider the Employee to be a Late Enrollee. Late Enrollees are subject to this Policy's Pre-Existing Conditions limitation, if any applies.

When an Employee initially waives coverage under this Policy, the Plan Sponsor or Horizon BCBSNJ should notify the Employee of the requirement for the Employee to make a statement that waiver was because he or she was covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If an Employee initially waived coverage under this Policy and the Employee stated at that time that such waiver was because he or she was covered under another group plan, and Employee now elects to enroll under this Policy, Horizon BCBSNJ will not consider the Employee and his or her Dependents to be Late Enrollees, provided the coverage under the other plan ends due to one of the following events:
a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union or termination of the domestic partnership;
e) death of the Employee's spouse;
f) termination of the Employer's contribution toward coverage; or

g) termination of the other plan's coverage.

But, the Employee must enroll under this Policy within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

If an Employee initially waived coverage under this Policy because he or she had coverage under a Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage under this Policy within 30 days of the date the COBRA continuation ended, Horizon BCBSNJ will not consider the Employee to be a Late Enrollee. Coverage will take effect as of the date the COBRA continuation ended.

In addition, an Employee and any Dependents will not be considered Late Enrolleesif the Employee is employed by an employer which offers multiple Health Benefits Plans and the Employee elects a different plan during the open enrollment period.

Further, an Employee and his or her Dependent spouse, if any, will not be considered Late Enrollees because the Employee initially waived coverage under this Policy for himself or herself and any then existing Dependents provided the Employee enrolls to cover himself or herself and his or her existing Dependent spouse, if any, under this Policy within 30 days of the marriage, birth, adoption or placement for adoption of a Newly Acquired Dependent.

The Waiting Period

This Policy has the following waiting periods:

Employees in an eligible class on the Effective Date, who have completed at least **0** months of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the Effective Date.

Employees in an eligible class on the Effective Date, who have not completed at least **0** months of continuous Full-Time service with the Policyholder by that date, are eligible for insurance under this Policy from the day after Employees complete **0** months of continuous Full-Time service.

Employees who enter an eligible class after the Effective Date are eligible for insurance under this Policy from the day after Employees complete **0** months of continuous Full-Time service with the Policyholder.

Any lapse in continuous service due to an absence which results from a Health Status-Related factor will reduce the days of Full-Time service by the number of days of absence. Such lapse in continuous Full-Time service will not require that the period of continuous Full-Time service begin anew.

Multiple Employment

If an Employee works for both the Policyholder and a covered Affiliated Company, or for more than one covered Affiliated Company, Horizon BCBSNJ will treat the Employee as if only one entity employs the Employee. And such an Employee will not have multiple coverage under this Policy. But, if this Policy uses the amount of an Employee's earnings or number of work hours to determine class, or for any other reason, such Employee's earnings or number of work hours will be figured as the sum of his or her earnings or work hours from all Affiliated Companies.

When Employee Coverage Starts

Except where an Employee is not Actively at Work due to a Health Status-Related Factor, and except as stated below, an Employee must be Actively at Work, and working his or her regular number of

hours, on the date his or her coverage is scheduled to start. And he or she must have met all the conditions of eligibility which apply to him or her. If an Employee is not Actively at Work on the scheduled Effective Date, and does not qualify for the exception to the Actively at Work requirement, Horizon BCBSNJ will postpone the start of his or her coverage until he or she returns to Active Work.

Sometimes, a scheduled Effective Date is not a regularly scheduled work day. But an Employee's coverage will start on that date if he or she was Actively at Work, and working his or her regular number of hours, on his or her last regularly scheduled work day.

The Employee must elect to enroll and agree to make the required payments, if any, within 30 days of the Employee's Eligibility Date. If he or she does this within 30 days of the Employee's Eligibility Date, his or her coverage is scheduled to start on the Employee's Eligibility Date. Such Employee's Eligibility Date is the Effective Date of an Employee's coverage.

If the Employee does this more than 30 days after the Employee's Eligibility Date, Horizon BCBSNJ will consider the Employee a Late Enrollee. Coverage is scheduled to start on the date the Horizon BCBSNJ or Horizon BCBSNJ's authorized representative or agent receives the signed enrollment form.

EXCEPTION to the Actively at Work Requirement
The Exception applies if the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier. An Employee who is not Actively at Work due to Total Disability on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:

a) the Employee was validly covered under the Policyholder's old plan on the date the Policyholder's old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

Except as stated below, the coverage under this Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Policy will end one year from the date the person's coverage under this Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder's old plan. Thereafter, coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Policy.
Exception: If the coverage under this Policy is richer than the coverage under the Policyholder's old plan, this Policy will provide coverage for services and supplies related to the disabling condition. This Policy will coordinate with the Policyholder's old plan, with this Policy providing secondary coverage, as described in the Coordination of Benefits and Services provision

When Employee Coverage Ends
An Employee's insurance under this Policy will end on the first of the following dates:

a) the date an Employee ceases to be an Actively at Work a Full-Time Employee for any reason. Such reasons include death, retirement, lay-off, leave of absence, and the end of employment.
b) the date an Employee stops being an eligible Employee under this Policy.
c) the date this Policy ends, or is discontinued for a class of Employees to which the Employee belongs.
d) the last day of the period for which required payments are made for the Employee, subject to the **Payment of Premiums - Grace Period section.**

DEPENDENT COVERAGE

Eligible Dependents for Dependent Health Benefits

An Employee's eligible Dependents are the Employee's:

a) legal spouse which shall include a civil union partner pursuant to P.L. 2006, c. 103 as well as same sex relationships legally recognized in other jurisdictions when such relationships provide substantially all of the rights and benefits of marriage. and domestic partner pursuant to P.L. 2003, c. 246;; except that legal spouse shall be limited to spouses of a marriage as marriage is defined in the Federal Defense of Marriage Act, 1 U.S.C.A. 7, with respect to:

- the provisions of the Policy regarding continuation rights required by the Federal Consolidated Omnibus Reconciliation Act of 1986 (COBRA), Pub. L. 99-272, as subsequently amended) (Neither domestic partners nor civil union partners have COBRA rights.)
- the provisions of this Policy regarding Medicare Eligibility by reason of Age and Medicare Eligibility by Reason of Disability.

b) Dependent children who are under age 26.

Under certain circumstances, an incapacitated child is also a Dependent. See the **Incapacitated Children** section of this Policy.

An Employee's "Dependent child" includes:

a) his or her legally adopted children,
b) his or her step-child,
c) the child of his or her civil union partner, and
d) the child of his or her domestic partner, and
e) children under a court appointed guardianship.

Horizon BCBSNJ treats a child as legally adopted from the time the child is placed in the home for purpose of adoption. Horizon BCBSNJ treats such a child this way whether or not a final adoption order is ever issued.

Incapacitated Children

An Employee may have an unmarried child with a mental or physical incapacity, or Developmental Disability, who is incapable of earning a living. Subject to all of the terms of this section and this Policy, such a child may stay eligible for Dependent health benefits past this Policy's age limit for eligible Dependents.

The child will stay eligible as long as the child stays unmarried and incapable of earning a living, if:

a) the child's condition started before he or she reached this Policy's age limit;
b) the child became insured by this Policy or any other policy before the child reached the age limit and stayed continuously insured after reaching such limit; and
c) the child depends on the Employee for most of his or her support and maintenance.

But, for the child to stay eligible, the Employee must send Horizon BCBSNJ written proof that the child is incapacitated or Developmentally Disabled and depends on the Employee for most of his or her support and maintenance. The Employee has 31 days from the date the child reaches the age limit to do this. Horizon BCBSNJ can ask for periodic proof that the child's condition continues. But, after two years, Horizon BCBSNJ cannot ask for this more than once a year.

The child's coverage ends when the Employee's coverage ends.

Enrollment Requirement

An Employee must enroll his or her eligible Dependents in order for them to be covered under this Policy. Horizon BCBSNJ considers an eligible Dependent to be a Late Enrollee, if the Employee:

a) enrolls a Dependent and agrees to make the required payments more than 30 days after the Dependent's Eligibility Date;
b) in the case of a Newly Acquired Dependent, has other eligible Dependents whose coverage previously ended because the Employee failed to make the required contributions, or otherwise chose to end such coverage.

Late Enrollees age 19 or older are subject to this Policy's Pre-Existing Conditions limitations section, if any applies.

If the Employee's dependent coverage ends for any reason, including failure to make the required payments, his or her Dependents will be considered Late Enrollees when their coverage begins again.

When an Employee initially waives coverage for a spouse and/or eligible Dependent children under this Policy, the Plan Sponsor or Horizon BCBSNJ should notify the Employee of the requirement for the Employee to make a statement that waiver was because the spouse and/or eligible Dependent children were covered under another group plan, if such other coverage was in fact the reason for the waiver, and the consequences of that requirement. If the Employee previously waived coverage for the Employee's spouse or eligible Dependent children under this Policy and stated at that time that, such waiver was because they were covered under another group plan and the Employee now elects to enroll them in this Policy, the Dependent will not be considered a Late Enrollee, provided the Dependent's coverage under the other plan ends due to one of the following events:

a) termination of employment or eligibility;
b) reduction in the number of hours of employment;
c) involuntary termination;
d) divorce or legal separation or dissolution of the civil union; or termination of the domestic partnership,
e) death of the Employee's spouse;
f) termination of the contribution toward coverage that was being made by the employer that offered the group plan under which the Dependent was covered; or
g) termination of the other plan's coverage.

But, the Employee's spouse or eligible Dependent children must be enrolled by the Employee within 90 days of the date that any of the events described above occur. Coverage will take effect as of the date the applicable event occurs.

And, Horizon BCBSNJ will not consider an Employee's spouse or eligible Dependent children for which the Employee initially waived coverage under this Policy, to be a Late Enrollee, if:

a) the Employee is under legal obligation to provide coverage due to a court order; and
b) the Employee's spouse or eligible Dependent children are enrolled by the Employee within 30 days of the issuance of the court order.

Coverage will take effect as of the date required pursuant to a court order.

In addition, if an Employee initially waived coverage under this Policy for the Employee's spouse or eligible Dependent children because the spouse and/or Dependent children had coverage under a

Consolidated Omnibus Budget Reconciliation Act (COBRA) continuation provision and the Employee requests coverage for the spouse and/or Dependent children under this Policy within 30 days of the date the COBRA continuation ended, Horizon BCBSNJ will not consider the spouse and/or Dependent children to be Late Enrollees. Coverage will take effect as of the date the COBRA continuation ended.

When Dependent Coverage Starts
In order for an Employee's dependent coverage to begin the Employee must already be insured for Employee coverage or enroll for Employee and Dependent coverage at the same time. Subject to all of the terms of this Policy, the date an Employee's dependent coverage starts depends on when the Employee elects to enroll the Employee's Initial Dependents and agrees to make any required payments.

If the Employee does this within 30 days of the Dependent's Eligibility Date, the Dependent's Coverage is scheduled to start on the later of:
a) the Dependent's Eligibility Date, or
b) the date the Employee becomes insured for Employee coverage.

If the Employee does this more than 30 days after the Dependent's Eligibility Date, Horizon BCBSNJ will consider the Dependent a Late Enrollee. Coverage is scheduled to start on the later of:
a) the date the Horizon BCBSNJ or Horizon BCBSNJ's authorized representative or agent receive the signed enrollment form; or
b) the date the Employee becomes insured for Employee coverage.

Once an Employee has dependent coverage for Initial Dependents the Employee must notify Horizon BCBSNJ of a Newly Acquired Dependent within 30 days after the Newly Acquired Dependent's Eligibility Date. If the Employee does not, the Newly Acquired Dependent is a Late Enrollee.

A Newly Acquired Dependent other than a newborn child or newly adopted child, including a child placed for adoption, will be covered from the later of:
a) the date the Employee notifies Horizon BCBSNJ and agrees to make any additional payments, or
b) the Dependent's Eligibility Date for the Newly Acquired Dependent.

If the Policyholder who purchased this Policy purchased it to replace a plan the Policyholder had with some other carrier, a Dependent who is Totally Disabled on the date this Policy takes effect will initially be eligible for limited coverage under this Policy if:
a) the Dependent was validly covered under the Policyholder’s old plan on the date the Policyholder’s old plan ended; and
b) this Policy takes effect immediately upon termination of the prior plan.

The coverage under this Policy will be limited to coverage for services or supplies for conditions other than the disabling condition. Such limited coverage under this Policy will end one year from the date the person’s coverage under this Policy begins. Coverage for services or supplies for the disabling condition will be provided as stated in an extended health benefits, or like provision, contained in the Policyholder’s old plan. Thereafter coverage will not be limited as described in this provision, but will be subject to the terms and conditions of this Policy.

Newborn Children
Horizon BCBSNJ will cover an Employee's newborn child for 31 days from the date of birth without additional premium. Health benefits may be continued beyond such 31-day period as stated below:

a) If the Employee is already covered for Dependent child coverage on the date the child is born, coverage automatically continues beyond the initial 31 days, provided the premium required for Dependent child coverage continues to be paid..The Employee must notify Horizon BCBSNJ of the birth of the newborn child as soon as possible in order that Horizon BCBSNJ may properly provide benefits under this Policy.

b) If the Employee is not covered for Dependent child coverage on the date the child is born, the Employee must:

- give written notice to enroll the newborn child; and
- pay the premium required for Dependent child coverage within 31 days after the date of birth.

If the notice is not given and the premium is not paid within such 31-day period, the newborn child's coverage will end at the end of such 31-day period. If the notice is given and the premium paid after that 31-day period, the child will be a Late Enrollee.

When Dependent Coverage Ends

A Dependent's insurance under this Policy will end on the first of the following dates:

a) the date Employee coverage ends;

b) the date the Employee stops being a member of a class of Employees eligible for such coverage;

c) the date this Policy ends;

d) the date Dependent coverage is terminated from this Policy for all Employees or for an Employee's class.

e) the date an Employee fails to pay any required part of the cost of Dependent coverage. It ends on the last day of the period for which the Employee made the required payments, unless coverage ends earlier for other reasons.

f) at 12:01 a.m. on the date the Dependent stops being an eligible Dependent.

POINT OF SERVICE PROVISIONS

Definitions

a) ***Primary Care Practitioner*** (PCP) means the Practitioner the Covered Person selects to supervise and coordinate his or her health care in the Horizon Managed Care Network Provider Organization. Horizon BCBSNJ will supply the Covered Person with a list of PCPs who are members of the Horizon Managed Care Network Provider Organization.
b) ***Provider Organization*** (PO) means a network of health care Providers located in a Covered Person's Service Area.
c) ***Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner provides care, treatment, services, and supplies to the Covered Person or if the Primary Care Practitioner refers the Covered Person to another Provider for such care, treatment, services, and supplies.
d) ***Non-Network Benefits*** means the benefits shown in the Schedule which are provided if the Primary Care Practitioner does not authorize the care, treatment, services, and supplies.
e) ***Service Area*** means the geographical area which is served by the Practitioners in the Horizon Managed Care Network Provider Organization.

Provider Organization (PO)
The Provider Organization for this Policy is the Horizon Managed Care Network Provider Organization. This Policy requires that the Covered Person use the services of a PCP, or be referred for services by a PCP, in order to receive Network Benefits. The Covered Person will periodically be given up-to-date lists of Horizon Managed Care Network PO Providers. The up-to-date lists will be furnished automatically, without charge.

The Primary Care Practitioner (PCP)
The PCP will supervise and coordinate the Covered Person's health care in the Horizon Managed Care Network PO. The PCP must authorize all services and supplies. In addition, he or she will refer the Covered Person to the appropriate Practitioner and Facility when Medically Necessary and Appropriate. The Covered Person must obtain an authorized Referral from his or her PCP before he or she visits another Practitioner or Facility. Except in case of Urgent Care or an Emergency, if the Covered Person does not comply with these requirements, he or she may only be eligible for Non-Network Benefits.

Horizon BCBSNJ provides Network Benefits for covered services and supplies furnished to a Covered Person when authorized by his or her PCP. Horizon BCBSNJ pays Non-Network Benefits when covered services and supplies are not authorized by the PCP. However, if the PCP refers a Covered Person to a Non-Network Provider for a service or supply, the service or supply shall be covered as a Network service or supply and Horizon BCBSNJ is fully responsible for payment to the Provider and the Covered Person is only responsible for any applicable Network level Copayment, Coinsurance or Deductible for the service or supply.

If services or supplies are obtained from Horizon Managed Care Network Providers even though they are not authorized by the PCP, the Covered Person will be eligible for Non-Network Benefits where the Horizon Managed Care Network provider's charges and the Covered Person's liability are limited to the negotiated fee for the service or supply.

A Covered Person may change his or her PCP to another PCP once per month. He or she may select another PCP from the list of Practitioners, and notify Horizon Managed Care Network PO by phone or in writing. For a discretionary change, the new PCP selection will take effect no more than

14 days following the date of the request. For a change necessitated by termination of the prior PCP from the Network, the new PCP selection will take effect immediately.

When a Covered Person uses the services of a PCP, he or she must present his or her ID card and pay the Copayment. When a Covered Person's PCP refers him or her to another Horizon Managed Care Network PO Provider, the Covered Person must pay the Copayment to such Provider. Most Horizon Managed Care Network PO Practitioners will prepare any necessary claim forms and submit them to Horizon BCBSNJ.

A female Covered Person may use the services of a Horizon Managed Care Network PO gynecologist for non-surgical gynecological care and routine pregnancy care without Referral from her PCP. She must obtain authorization from her PCP for other services.

Non-Network Services
If a Covered Person uses the services of a Provider without having been referred by his or her PCP, he or she will not be eligible for Network Benefits. Except as stated below, for services which have not been referred by the Covered Person's PCP, whether provided by an Horizon Managed Care Network PO Provider or otherwise, the Covered Person may only be eligible for Non-Network Benefits. Exception: If a Covered Person is admitted to a Network Facility by a Non-Network Provider, the Network Facility will nevertheless be paid Network benefits.

Emergency Services
If a Covered Person requires services for Urgent Care or an Emergency which occurs inside the PO Service Area, he or she must notify his or her PCP within 48 hours or as soon as reasonably possible thereafter.

Emergency room visits to PO Facilities are subject to a Copayment, and such visits must be retrospectively reviewed by the PCP. Horizon BCBSNJ will waive the emergency room Copayment if the Covered Person is hospitalized within 24 hours of the visit.

In the case of Urgent Care or an Emergency, a Covered Person may go to a Horizon Managed Care Network Provider or a non-Horizon Health Care Network provider. If a Covered Person receives Urgent Care or care and treatment for an Emergency from a non-Horizon Health Care Network provider, and the Covered Person calls Horizon BCBSNJ within 48 hours, or as soon as reasonably possible, Horizon BCBSNJ will provide benefits for the Urgent Care or Emergency care and treatment to the same extent as would have been provided if care and treatment were provided by a Horizon Health Care Network provider. However, follow-up care or treatment by a non-Horizon Health Care Network provider will be treated as Network Benefits only to the extent it is Medically Necessary and Appropriate care or treatment rendered before the Covered Person can return to the Horizon Health Care Network service area.

Utilization Review
This Policy has utilization features. See the **Utilization Review Features** section of this Policy.

Benefits
The Schedule shows Network Benefits, Non-Network Benefits, and Copayments applicable to the Point of Service arrangement. What Horizon BCBSNJ pays is subject to all the terms of this Policy.

Service Area
The Service Area is the State of New Jersey.

Different providers in Our Network have agreed to be paid in different ways by Us. A Provider may be paid each time he or she treats a Covered Person (“fee for service”) or may be paid a set fee for each month for each Covered Person whether or not the Covered Person actually receives services ("capitation"). These payment methods may include financial incentive agreements to pay some providers more ("bonuses") or less ("withholds") based on many factors: Covered Person satisfaction, quality of care, and control of costs and use of services among them. If a Covered Person desires additional information about how Our primary care physicians or any other Provider in Our Network are compensated, please call Us at 1-800-355-2583 or write Horizon BCBSNJ, PO Box 1609, Newark, NJ 07101.

The laws of the state of New Jersey, at N.J.S.A. 45:9-22.4 et seq., mandate that a physician, chiropractor or podiatrist who is permitted to make Referrals to other health care Providers in which he or she has a significant financial interest inform his or her patients of any significant financial interest he or she may have in a health care Provider or Facility when making a Referral to that health care Provider or Facility. If a Covered Person wants more information about this, contact the Covered Person’s physician, chiropractor or podiatrist. If a Covered Person believes he or she is not receiving the information to which he or she is entitled, contact the Division of Consumer Affairs in the New Jersey Department of Law and Public Safety at (973) 504-6200 OR (800) 242-5846.

APPEALS PROCEDURE

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) may appeal Horizon BCBSNJ's administrative and utilization review (UR) decisions. Administrative decisions involve benefit issues. UR decisions involve a denial, termination or other limitation of covered health care services. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon BCBSNJ. The appeal process consists of: (a) an informal internal review by Horizon BCBSNJ; (b) a formal internal review by Horizon BCBSNJ; and (c) a formal external review by an independent utilization review organization (IURO). The external review by an IURO is only available for UR decisions. Nothing in Horizon BCBSNJ's policies, procedures or Provider contracts prevents a Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) from discussing or exercising the right to an appeal.

A Covered Person must follow the steps for filing the three levels of appeal. If these steps are not followed, the Covered Person's appeal review may be delayed. Also, in the case of a UR matter, the Covered Person may be prevented from pursuing an external review. If Horizon BCBSNJ fails to comply with the appeals process or expressly waives its rights to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) may proceed directly to the formal external review.

a. First Level Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss an adverse medical decision directly with the Horizon BCBSNJ physician who made it, or with the medical director designated by Horizon BCBSNJ. All First Level Appeals must be made within 180 days/12 months from the date that Horizon BCBSNJ informed the Covered Person of the denial of coverage or payment.
To submit a First Level Appeal, the Covered Person must include the following information:

1) the name(s) and address(es) of the Covered Person(s) or Provider(s) involved;
2) the Covered Person's ID number;
3) the date(s) of service;
4) the details regarding the actions in question;
5) the nature of and reason behind the appeal;
6) the remedy sought; and
7) the documentation to support the appeal.

We will inform Covered Persons of decisions about administrative First Level Appeals within 30 calendar days after receipt of the required documentation. We will inform Covered Persons of decisions about UR First Level Appeals regarding Medical Emergency or Urgent Care issues within 72 hours from receipt of the required documentation (including all situations in which the Covered Person is confined as an Inpatient), and within five business days of receipt of the required documentation for all other UR issues. Horizon BCBSNJ will provide the Covered Person and/or the Provider with; (a) written notice of the outcome; (b) the reasons for the decision; and (c) instructions for filing a Second Level Appeal.

b. Second Level Appeal

If a Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level Appeal decision, the Covered Person or Provider can file a Second Level Appeal before a panel of physicians and/or other health care professionals selected by Horizon BCBSNJ who were not involved in the original and First Level Appeal decisions. At the Covered Person's request, the Provider involved in the original medical decision may take part in the process.

Horizon BCBSNJ will acknowledge Second Level Appeals in writing within ten business days of receipt. We will provide written notice of the final decision on the appeal: (a) within 72 hours after receipt (in the case of UR appeals that require review on an expedited basis due to a Medical Emergency, Urgent Care or a Medical Necessity and Appropriateness issue); and (b) within 20 business days of receipt in the case of all other UR appeals.

Horizon BCBSNJ may extend the review for up to an additional 20 business days when: (a) there is a reasonable cause for the delay that is beyond Horizon BCBSNJ's control; and (b) the explanation satisfies the New Jersey Department of Banking and Insurance (DOBI). Horizon BCBSNJ will provide the Covered Person or Provider with written notice of the delay within the original 20 day period.

If the Second Level Appeal is denied, Horizon BCBSNJ will provide the Covered Person and/or Provider with written notice of the reasons for the denial, together with a written notice of his/her right to proceed to an external appeal. Horizon BCBSNJ will include specific instructions as to how the Covered Person and/or Provider may arrange for an external appeal and will also include any forms needed to start the appeal.

c. External Appeal

A Covered Person (or a Provider acting for the Covered Person, with the Covered Person's consent) who is dissatisfied with the results from Horizon BCBSNJ's internal appeal process can pursue an External Appeal with an IURO assigned by the DOBI. The Covered Person's right to such an appeal depends on the Covered Person's full compliance with both stages of Horizon BCBSNJ's internal appeal process. However, if, at any time during that process, Horizon BCBSNJ fails to handle the appeal within the applicable time frame set forth in a. or b., the Covered Person or his/her designated Provider can proceed immediately to pursue the External Appeal.

To start an External Appeal, the Covered Person or Provider must submit a written request within 60 business days from receipt of the written decision about the Second Level Appeal (or, within 60 business days from the last date of the filing of an appeal regarding which Horizon BCBSNJ failed to meet the required time frame set forth in a. or b., above). The Covered Person or Provider must use the required forms and include both: (a) a $25.00 check made payable to "New Jersey Department of Banking and Insurance"; and (b) an executed release to enable the IURO to obtain all medical records pertinent to the appeal, to:

Office of Managed Care
New Jersey Department of Banking and Insurance
P.O. Box 360
Trenton, NJ 08625-0360

If the Covered Person cannot afford to pay the fee, the fee may be reduced to a $2.00 fee if the Covered Person can show proof of financial hardship. Proof of financial hardship can be

demonstrated through evidence that one or more members of the household is receiving aid or benefits under: Pharmaceutical Assistance to the Aged and Disabled; Medicaid; General Assistance; Social Security Insurance; NJ Kid Care; or the New Jersey Unemployment Assistance program.

Upon receipt of the appeal, together with the executed release and the appropriate fee, the DOBI shall immediately assign the appeal to an IURO to conduct a preliminary review and accept it for process. But, this will happen only if the DOBI finds that:

1. The person is or was a Covered Person of Horizon BCBSNJ;
2. The service or supply which is the subject of the appeal reasonably appears to be a Covered Service or Supply under the Covered Person's Program;

3. The Covered Person has fully complied with both levels of Horizon BCBSNJ's internal appeals system (or, alternatively, that Horizon BCBSNJ failed to meet the time frames in its internal appeals system); and

4. The Covered Person has furnished all information needed by the IURO and the DOBI to make the preliminary determination. This includes: the appeal form; a copy of any information furnished by Horizon BCBSNJ regarding its decision to deny, reduce or terminate the Covered Service or Supply; and the fully executed release.

Upon completion of this review, the IURO will immediately inform the Covered Person or Provider, in writing, as to whether or not the appeal has been accepted for review. If it is not accepted, the IURO will give the reasons. If the appeal is accepted, the IURO will complete its review and issue its recommended decision within 30 business days from receipt of all documentation needed to complete its review (or within 48 hours from such receipt, if the appeal involves emergency or urgent care).

The IURO may extend the period of review for a reasonable period of time, if it is needed due to circumstances beyond its control. But, in no event will it render its decision later than 90 calendar days following receipt of a completed application. In such an event, prior to the conclusion of the 30 business day review, the IURO will provide written notice to the Covered Person or Provider, the DOBI and Horizon BCBSNJ describing the status of its review and the specific reasons for the delay.

When the IURO completes its review, it will state its findings in writing and make a determination of whether our denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment.
If the IURO determines that the denial, reduction, or termination of benefits deprived the Covered Person of Medically Necessary and Appropriate treatment, this will be conveyed to the Covered Person and Horizon BCBSNJ. The IURO will also describe the Medically Necessary and Appropriate services that should be received. This determination is binding upon us. If all or part of the IURO's decision is in favor of the Covered Person, Horizon BCBSNJ will provide coverage for those Covered Services and Supplies that are determined to be Medically Necessary and Appropriate. If the Covered Person and/or Provider do not agree with the IURO's decision, he/she may seek the desired health care services outside of the Program.

PHARMACY APPEALS

A Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) may appeal administrative and UR determinations, regarding the Pharmacy benefit program. Administrative determinations involve benefit issues. For example, if Horizon BCBSNJ decides not to cover the extra cost of a brand name Prescription Drug when there is a generic

equivalent, and the Covered Person (or his/her Practitioner) believe that the brand name drug is needed, the Covered Person (or Practitioner) has the right to appeal the decision. UR determinations involve a denial, termination or other limitation of covered Pharmacy benefits, including Medical Necessity and Appropriateness determinations. No Covered Person or Provider who files an appeal will be subject to disenrollment, discrimination or penalty by Horizon Blue Cross Blue Shield of New Jersey.

The appeal process consists of an informal internal review by us, a formal internal review by us and a formal external review by the Independent Health Care Appeals Program in the Department of Banking and Insurance (DOBI). Nothing in our policies, procedures or Provider agreements shall prohibit a Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) from discussing or exercising the right to an appeal.

A Covered Person must follow the steps for filing the three levels of appeal as outlined in this Booklet. If these procedures are not followed, the Covered Person's appeal review may be delayed or the Covered Person may be prohibited from pursuing an external review. If we fail to comply with the appeals process or the Covered Person expressly waives their right to an internal review of any appeal, then the Covered Person (or Provider acting on behalf of the Covered Person and with the Covered Person's consent) may proceed directly to the formal external review.

a. First Level Appeal

A Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) can file a First Level Appeal by calling or writing Horizon BCBSNJ at the telephone number and address on the Covered Person's ID card. At the First Level Appeal, a Covered Person may discuss any medical determination made by us directly with the physician who issued that determination or the medical director designated by us. All First Level Appeals must be made within 12 months from the date the Covered Person was notified by us of the original denial for coverage or payment.

To submit a First Level Appeal, the Covered Person must include the following information:

1. the name and address(es) of the Covered Person(s) or Provider(s) involved;
2. the Covered Person's ID number;
3. the date(s) of purchase of attempted purchase;
4. the details regarding the actions in question;
5. the nature and reason behind the appeal;
6. the remedy sought; and
7. the documentation to support the appeal.

The Covered Person will be notified of determinations of administrative First Level Appeals within 30 days from receipt of the required documentation. The Covered Person will be notified of determinations of UR First Level Appeals from Medical Emergency or Urgent Care decisions within 72 hours from receipt of the required documentation and within two business days of receipt of the required documentation for all others. We will provide the Covered Person and/or the Provider written notification of the outcome, the reasons for the determination and instructions for filing a Second Level Appeal.

b. Second Level Appeal

If a Covered Person (or a Provider acting on behalf of the Covered Person and with the Covered Person's consent) is not satisfied with Horizon BCBSNJ's First Level determination, the Covered Person or Provider can file a Second Level Appeal before a panel of physicians and/or other health care professionals selected by us who have not been involved in the UR determination at issue. At the Covered Person's request, the health care Provider involved in the original medical determination may participate in the decision with the panel.

We will acknowledge Second Level Appeals in writing within five business days of receipt. Within 72 hours of receipt for UR appeals that, due to Medical Necessity and Appropriateness require review on an expedited basis, and within 20 business days of receipt for all other UR appeals, the Covered Person will receive written notification of the final determination of the appeal, the reasons for it and instructions for filing an External appeal with the necessary forms. In the case of UR determination appeals that are responded to within 20 business days of receipt, we may extend the review for up to an additional 20 business days where reasonable cause for the delay exists which is beyond our control. We will provide the Covered Person or Provider with a written progress report within 20 business days of receipt of the Second Level Appeal. The written progress report will comply with the applicable requirements promulgated by the DOBI.

c. External Appeal

After an internal appeal has been conducted and a Covered Person has received a final determination, he/she may request an external appeal in the event of a denial, reduction or termination of benefits. The appeal provides an independent Medical Necessity or Appropriateness of services review. A Covered Person may appeal to the Independent Health Care Appeals Program for a review of a decision to deny, reduce or terminate a benefit if: (a) Horizon BCBSNJ has failed to handle an appeal within the applicable time frame; or (b) the person has already completed Horizon BCBSNJ's internal appeal process and has contested the final determination. The Covered Person must apply to the DOBI within 60 business days of the date the final determination was issued by Horizon, or from the last date of the filing of an appeal for which Horizon BCBSNJ failed to meet a required time frame. The Covered Person must provide the DOBI with:

1. The name and address of the carrier;
2. A brief description of the Covered Person's medical condition for which benefits were denied, reduced or terminated;
3. A copy of any information provided by the carrier regarding its decision to deny, reduce or terminate the benefit; and
4. A written consent to obtain any necessary medical records from the carrier and any other Out-of-Network physician the Covered Person may have consulted on the matter.

The Covered Person must pay the Department an application processing fee of $25, except that the Commissioner may reduce or waive the fee in the case of financial hardship.

CONTINUATION OF CARE

Horizon BCBSNJ shall provide written notice to each Covered Person at least 30 business days prior to the termination or withdrawal from Horizon BCBSNJ's Provider network of a Covered Person's PCP and any other Provider from which the Covered Person is currently receiving a course of treatment, as reported to Horizon BCBSNJ. The 30-day prior notice may be waived in cases of immediate termination of a health care professional based on a breach of contract by the health care professional, a determination of fraud, or where Horizon BCBSNJ's medical director is of the opinion that the health care professional is an imminent danger to the patient or the public health, safety or welfare.

Horizon BCBSNJ shall assure continued coverage of covered services at the contract rate by a terminated health care professional for up to four months in cases where it is Medically Necessary and Appropriate for the Covered Person to continue treatment with the terminated health care professional. In case of pregnancy of a Covered Person, coverage of services for the terminated health care professional shall continue to the postpartum evaluation of the Covered Person, up to six weeks after the delivery. With respect to pregnancy, Medical Necessity and Appropriateness shall be deemed to have been demonstrated.

For a Covered Person who is receiving post-operative follow-up care, Horizon BCBSNJ shall continue to cover the services rendered by the health care professional for the duration of the treatment or for up to six months, whichever occurs first.

For a Covered Person who is receiving oncological treatment or psychiatric treatment, Horizon BCBSNJ shall continue to cover services rendered by the health care professional for the duration of the treatment or for up to 12 months, whichever occurs first.

For a Covered Person receiving the above services in an acute care Facility, Horizon BCBSNJ will continue to provide coverage for services rendered by the health care professional regardless of whether the acute care Facility is under contract or agreement with Horizon BCBSNJ.

Services shall be provided to the same extent as provided while the health care professional was employed by or under contact with Horizon BCBSNJ. Reimbursement for services shall be pursuant to the same schedule used to reimburse the health care professional while the health care professional was employed by or under contract with Horizon BCBSNJ.

If a Covered Person is admitted to a health care Facility on the date this Policy is terminated, Horizon BCBSNJ shall continue to provide benefits for the Covered Person until the date the Covered Person is discharged from the facility or exhaustion of the Covered Person's benefits under this Policy, whichever occurs first.

Horizon BCBSNJ shall not continue services in those instances in which the health care professional has been terminated based upon the opinion of Horizon BCBSNJ's medical director that the health care professional is an imminent danger to a patient or to the public health, safety and welfare, a determination of fraud or a breach of contract by a health care professional. The determination of the Medical Necessity and Appropriateness of a Covered Person's continued treatment with a health care professional shall be subject to the appeal procedures set forth in this Policy. Horizon BCBSNJ shall not be liable for any inappropriate treatment provided to a Covered Person by a health care professional who is no longer employed by or under contract with Horizon BCBSNJ.

If Horizon BCBSNJ refers a Covered Person to a Non-Network provider, the service or supply shall be covered as a network service or supply. Horizon BCBSNJ is fully responsible for payment to the health care professional and the Covered Person's liability shall be limited to any applicable Network Copayment, Coinsurance or Deductible for the service or supply.

HEALTH BENEFITS INSURANCE

This health benefits insurance will pay many of the medical expenses incurred by a Covered Person.

Note: Horizon BCBSNJ payments will be reduced if a Covered Person does not comply with the Utilization Review and Pre-Approval requirements contained in this Policy.

BENEFIT PROVISION

The Cash Deductible
Each Calendar Year, each Covered Person must have Covered Charges that exceed the Cash Deductible before Horizon BCBSNJ pays any benefits to that person. The Cash Deductible is shown in the Schedule. The Cash Deductible cannot be met with Non-Covered Charges Only Covered Charges incurred by the Covered Person while insured by this Policy can be used to meet this Cash Deductible.

Once the Cash Deductible is met, Horizon BCBSNJ pays benefits for other Covered Charges above the Cash Deductible incurred by that Covered Person, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. But all charges must be incurred while that Covered Person is insured by this Policy. And what Horizon BCBSNJ pays is based on all the terms of this Policy.

Family Deductible Limit
This Policy has a family deductible limit of two Cash Deductibles for each Calendar Year. Once two Covered Persons in a family meet their individual Cash Deductibles in a Calendar Year, Horizon BCBSNJ pays benefits for other Covered Charges incurred by any member of the covered family, less any applicable Coinsurance or Copayments, for the rest of that Calendar Year. What Horizon BCBSNJ pays is based on all the terms of this Policy.

Network Maximum Out of Pocket
Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Network Maximum Out of Pocket. Once the Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Non-Network Maximum Out of Pocket
Non-Network Maximum Out of Pocket means the annual maximum dollar amount that a Covered Person must pay as Copayment, Deductible and Coinsurance for all Non-Network covered services and supplies in a Calendar Year. All amounts paid as Copayment, Deductible and Coinsurance shall count toward the Non-Network Maximum Out of Pocket. Once the Non-Network Maximum Out of Pocket has been reached, the Covered Person has no further obligation to pay any amounts as Copayment, Deductible and Coinsurance for Non-Network covered services and supplies for the remainder of the Calendar Year.

Once any combination of Covered Persons in a family meet an amount equal to two times the individual Maximum Out of Pocket, no Covered Person in that family will be required to pay any amounts as Copayments, Deductible or Coinsurance for covered services and supplies for the remainder of the Calendar Year.

Payment Limits
Horizon BCBSNJ limits what Horizon BCBSNJ will pay for certain types of charges. Horizon BCBSNJ also limits what Horizon BCBSNJ will pay for all Illnesses or Injuries for each Covered Person's Per Lifetime. See the Schedule for these limits.

Benefits From Other Plans
The benefits Horizon BCBSNJ will pay may be affected by a Covered Person's being covered by two or more plans or policies. Read the provision **Coordination of Benefits** to see how this works.

The benefits Horizon BCBSNJ will pay may also be affected by Medicare. Read the **Medicare as Secondary Payor** section for an explanation of how this works.

If This Plan Replaces Another Plan
The Policyholder who purchased this Policy may have purchased it to replace a plan the Policyholder had with some other carrier.

The Covered Person may have incurred charges for covered expenses under the Policyholder's old plan before it ended. If so, these charges will be used to meet this Policy's Cash Deductible if:

a) the charges were incurred during the Calendar Year in which this Policy starts or during the 90 days preceding the effective date, whichever is the greater period;
b) this Policy would have paid benefits for the charges if his Policy had been in effect:
c) the Covered Person was covered by the old plan when it ended and enrolled in this Policy on its Effective Date; and
d) this Policy takes effect immediately upon termination of the prior plan.

Please note: Although Deductible credit is given, there is no credit for Coinsurance.

The Covered Person may have satisfied part of the eligibility Waiting Period under the Policyholder's old plan before it ended. If so, the time satisfied will be used to satisfy this Policy's eligibility waiting period if:
a) the Employee was employed by the Policyholder on the date the Policyholder's old plan ended: and
b) This Policy takes effect immediately upon termination of the prior plan.

Extended Health Benefits
If this Policy ends, and a Covered Person is Totally Disabled on such date, and under a Practitioner's care, Horizon BCBSNJ will extend health benefits for that person under this Policy as explained below. This is done at no cost to the Covered Person.

Horizon BCBSNJ will only extend benefits for Covered Charges due to the disabling condition. The charges must be incurred before the extension ends. And what Horizon BCBSNJ will pay is based on all the terms of this Policy.

Horizon BCBSNJ does not pay for charges due to other conditions. And Horizon BCBSNJ does not pay for charges incurred by other covered family members.

The extension ends on the earliest of:
a) the date the Total Disability ends;
b) one year from the date the person's insurance under this Policy ends; or
c) the date the person has reached the payment limit for his or her disabling condition.

The Employee must submit evidence to Horizon BCBSNJ that he or she or his or her Dependent is Totally Disabled, if Horizon BCBSNJ requests it.

COVERED CHARGES
This section lists the types of charges Horizon BCBSNJ will consider as Covered Charges. But what Horizon BCBSNJ will pay is subject to all the terms of this Policy. Read the entire Policy to find out what Horizon BCBSNJ limits or excludes.

Hospital Charges
Horizon BCBSNJ covers charges for Hospital room and board and Routine Nursing Care when it is provided to a Covered Person by a Hospital on an Inpatient basis. But Horizon BCBSNJ limits what Horizon BCBSNJ pays each day to the room and board limit shown in the Schedule. And Horizon BCBSNJ covers other Medically Necessary and Appropriate Hospital services and supplies provided to a Covered Person during the Inpatient confinement.

Except as stated below, Horizon BCBSNJ covers charges for Inpatient care for:
a) a minimum of 72 hours following a modified radical mastectomy; and
b) a minimum of 48 hours following a simple mastectomy.
Exception: The minimum 72 or 48 hours, as appropriate, of Inpatient care will not be covered if the Covered Person, in consultation with the Practitioner, determines that a shorter length of stay is medically necessary and appropriate.

As an **exception** to the Medically Necessary and Appropriate requirement of this Policy, Horizon BCBSNJ also provides coverage for the mother and newly born child for:
a) a minimum of 48 hours of Inpatient care in a Hospital following a vaginal delivery; and
b) a minimum of 96 hours of Inpatient Hospital care following a cesarean section.

Horizon BCBSNJ provides such coverage subject to the following:
a) the attending Practitioner must determine that Inpatient care is medically necessary; or
b) the mother must request the Inpatient care.
As an alternative to the minimum level of Inpatient care described above, the mother may elect to participate in a home care program provided by Horizon BCBSNJ.

If a Covered Person incurs charges as an Inpatient in a Special Care Unit, Horizon BCBSNJ covers the charges up to the daily room and board limit for a Special Care Unit shown in the Schedule.

Horizon BCBSNJ will also cover Outpatient Hospital services, including services provided by a Hospital Outpatient clinic. And Horizon BCBSNJ covers emergency room treatment, subject to this Policy's **Emergency Room Copayment Requirement** section.

Any charges in excess of the Hospital semi-private daily room and board limit are a Non-Covered Charge. This Policy's utilization review features have penalties for non-compliance that may reduce what Horizon BCBSNJ pays for Hospital charges.

Emergency Room Copayment Requirement
Each time a Covered Person uses the services of a Hospital emergency room, he or she must pay a $50.00 Copayment, in addition to the Cash Deductible, any other Copayments, and Coinsurance, if he or she is not admitted within 24 hours.

Emergency and Urgent Care Services
Coverage for Emergency and Urgent Care includes coverage of trauma services at any designated level I or II trauma center as Medically Necessary and Appropriate, which shall be continued at least until, in the judgement of the attending physician, the Covered Person is medically stable, no longer requires critical care, and can be safely transferred to another Facility. Horizon BCBSNJ also provides coverage for a medical screening examination provided upon a Covered Person's arrival in a Hospital, as required to be performed by the Hospital in accordance with Federal law, but only as necessary to determine whether an emergency medical condition exists. Please note that the "911" emergency response system may be used whenever a Covered Person has a potentially life-threatening condition. Information on the use of the "911" system is included on the identification card.

Pre-Admission Testing Charges
Horizon BCBSNJ covers pre-admission x-ray and laboratory tests needed for a planned Hospital admission or Surgery. Horizon BCBSNJ only covers these tests if, the tests are done on an Outpatient basis within seven days of the planned admission or Surgery.

However, Horizon BCBSNJ will not cover tests that are repeated after admission or before Surgery, unless the admission or Surgery is deferred solely due to a change in the Covered Person's health.

Extended Care or Rehabilitation Charges
Subject to Horizon BCBSNJ's Pre-Approval Horizon BCBSNJ covers charges up to the daily room and board limit for room and board and Routine Nursing Care shown in the Schedule, provided to a Covered Person on an Inpatient basis in an Extended Care Center or Rehabilitation Center. Charges above the daily room and board limit are a Non-Covered Charge.

And Horizon BCBSNJ covers all other Medically Necessary and Appropriate services and supplies provided to a Covered Person during the confinement. But the confinement must:

a) start within 14 days of a Hospital stay; and
b) be due to the same or a related condition that necessitated the Hospital stay.

Coverage for Extended Care and Rehabilitation, combined, is limited to the first 120 days of confinement in each Calendar Year. Charges for any additional days are a Non-Covered Charge.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for treatment, services and supplies for Extended Care or Rehabilitation which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Home Health Care Charges
Subject to Horizon BCBSNJ's Pre-Approval, when home health care can take the place of Inpatient care, Horizon BCBSNJ covers such care furnished to a Covered Person under a written home health care plan. Horizon BCBSNJ covers all Medically Necessary and Appropriate services or supplies, such as:
a) Routine Nursing care furnished by or under the supervision of a registered Nurse;

b) physical therapy;
c) occupational therapy;
d) medical social work;
e) nutrition services;
f) speech therapy;
g) home health aide services;
h) medical appliances and equipment, drugs and medications, laboratory services and special meals to the extent such items and services would have been covered under this Policy if the Covered Person had been in a Hospital; and
i) any Diagnostic or therapeutic service, including surgical services performed in a Hospital Outpatient department, a Practitioner's office or any other licensed health care Facility, provided such service would have been covered under the Policy if performed as Inpatient Hospital services.

Payment is subject to all of the terms of this Policy and to the following conditions:

a. The Covered Person's Practitioner must certify that home health care is needed in place of Inpatient care in a recognized Facility. Home health care is covered **only** in situations where continuing hospitalization or confinement in a Skilled Nursing Facility or Rehabilitation Center would otherwise have been required if Home Health Care were not provided.
b. The services and supplies must be:
    1. ordered by the Covered Person's Practitioner;
    2. included in the home health care plan: and
    3. furnished by, or coordinated by, a Home Health Agency according to the written home health care plan.

The services and supplies must be furnished by recognized health care professionals on a part-time or intermittent basis, except when full-time or 24 hour service is needed on a short-term (no more than three-day) basis.

c. The home health care plan must be set up in writing by the Covered Person's Practitioner within 14 days after home health care starts. And it must be reviewed by the Covered Person's Practitioner at least once every 60 days.
d. Horizon BCBSNJ does not pay for:
    1. services furnished to family members, other than the patient; or
    2. services and supplies not included in the home health care plan.

Any visit by a member of a home health care team on any day shall be considered as one home health care visit.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for treatment, services and supplies for Home Health Care which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Practitioner's Charges for Non-Surgical Care and Treatment
Horizon BCBSNJ covers Practitioner's charges for the Medically Necessary and Appropriate non-surgical care and treatment of an Illness or Injury.

Practitioner's Charges for Surgery
Horizon BCBSNJ covers Practitioner's charges for Medically Necessary and Appropriate Surgery.

Horizon BCBSNJ does not pay for Cosmetic Surgery unless it is required as a result of an Illness or Injury or to correct a functional defect resulting from a congenital abnormality or developmental anomaly.

Horizon BCBSNJ covers reconstructive breast Surgery, Surgery to restore and achieve symmetry between the two breasts and the cost of prostheses following a mastectomy on one breast or both breasts. Horizon BCBSNJ also covers treatment of the physical complications of mastectomy, including lymphedemas.

Second Opinion Charges
Horizon BCBSNJ covers Practitioner's charges for a second opinion and charges for related x-rays and tests when a Covered Person is advised to have Surgery or enter a Hospital. If the second opinion differs from the first, Horizon BCBSNJ covers charges for a third opinion. Horizon BCBSNJ covers such charges if the Practitioners who give the opinions:
a) are board certified and qualified, by reason of their specialty, to give an opinion on the proposed Surgery or Hospital admission;
b) are not business associates of the Practitioner who recommended the Surgery; and
c) in the case of a second surgical opinion, they do not perform the Surgery if it is needed.

Dialysis Center Charges
Horizon BCBSNJ covers charges made by a dialysis center for covered dialysis services.

Ambulatory Surgical Center Charges
Horizon BCBSNJ covers charges made by an Ambulatory Surgical Center in connection with covered Surgery.

Hospice Care Charges
Subject to Horizon BCBSNJ Pre-Approval, Horizon BCBSNJ covers charges made by a Hospice for palliative and supportive care furnished to a terminally Ill or terminally Injured Covered Person under a Hospice care program.

"Palliative and supportive care" means care and support aimed mainly at lessening or controlling pain or symptoms; it makes no attempt to cure the Covered Person's terminal Illness or terminal Injury.

"Terminally Ill" or "terminally Injured" means that the Covered Person's Practitioner has certified in writing that the Covered Person's life expectancy is six months or less.

Hospice care must be furnished according to a written "hospice care program". A "hospice care program" is a coordinated program with an interdisciplinary team for meeting the special needs of the terminally Ill or terminally Injured Covered Person. It must be set up and reviewed periodically by the Covered Person's Practitioner.

Under a Hospice care program, subject to all the terms of this Policy, Horizon BCBSNJ covers any services and supplies including Prescription Drugs, to the extent they are otherwise covered by this Policy. Services and supplies may be furnished on an Inpatient or Outpatient basis.

The services and supplies must be:
a) needed for palliative and supportive care;
b) ordered by the Covered Person's Practitioner;
c) included in the Hospice care program; and
d) furnished by, or coordinated by a Hospice.

Horizon BCBSNJ does not pay for:
a) services and supplies provided by volunteers or others who do not regularly charge for their services;
b) funeral services and arrangements;
c) legal or financial counseling or services; or
d) treatment not included in the Hospice care plan.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for treatment, services and supplies for Hospice Care which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Mental Illness or Substance Abuse
Horizon BCBSNJ pays benefits for the Covered Charges a Covered Person incurs for the treatment of Mental Illness or Substance Abuse the same way Horizon BCBSNJ would for any other Illness, if such treatment is prescribed by a Practitioner. But Horizon BCBSNJ does not pay for Custodial Care, education, or training.

Inpatient or day treatment may be furnished by any licensed, certified or State approved facility, including but not limited to:
a) a Hospital
b) a detoxification Facility licensed under New Jersey P.L. 1975, Chapter 305;
c) a licensed, certified or state approved residential treatment Facility under a program which meets the minimum standards of care of the Joint Commission;
d) a Mental Health Center; or
e) a Substance Abuse Center.

Pregnancy
This Policy pays for pregnancies the same way Horizon BCBSNJ would cover an Illness. The charges Horizon BCBSNJ covers for a newborn child are explained below.

Birthing Center Charges
Horizon BCBSNJ covers Birthing Center charges made by a Practitioner for pre-natal care, delivery, and post partum care in connection with a Covered Person's pregnancy. Horizon BCBSNJ covers charges up to the daily room and board limit for room and board shown in the Schedule when Inpatient care is provided to a Covered Person by a Birthing Center. But charges above the daily room and board limit are a Non-Covered Charge.

Horizon BCBSNJ covers all other Medically Necessary and Appropriate services and supplies during the confinement.

Benefits for a Covered Newborn Child
Horizon BCBSNJ covers charges for the child's routine nursery care while he or she is in the Hospital or a Birthing Center. Charges are covered up to a maximum of 7 days following the date of birth. This includes:

a) nursery charges;
b) charges for routine Practitioner's examinations and tests; and
c) charges for routine procedures, like circumcision.

Subject to all of the terms of this Policy, Horizon BCBSNJ covers the care and treatment of a covered newborn child if he or she is Ill, Injured, premature, or born with a congenital birth defect.

Anesthetics and Other Services and Supplies
Horizon BCBSNJ covers anesthetics and their administration; hemodialysis, casts; splints; and surgical dressings. Horizon BCBSNJ covers the initial fitting and purchase of braces, trusses, orthopedic footwear and crutches Horizon BCBSNJ covers Medically Necessary and Appropriate replacements or repairs for braces, trusses, orthopedic footwear and crutches.

Blood
Unless otherwise provided in the **Charges for the Treatment of Hemophilia** section below, Horizon BCBSNJ covers blood, blood products, blood transfusions and the cost of testing and processing blood. But Horizon BCBSNJ does not pay for blood which has been donated or replaced on behalf of the Covered Person.

Charges for the Treatment of Hemophilia
Horizon BCBSNJ covers Medically Necessary and Appropriate home treatment services for bleeding episodes associated with hemophilia including the purchase of blood products and blood infusion equipment.

Horizon BCBSNJ will cover the services of a clinical laboratory at a Hospital with a state-designated outpatient regional care center regardless of whether the Hospital's clinical laboratory is a Network Provider if the Covered Person's Practitioner determines that the Hospital's clinical laboratory is necessary because: a) the results of laboratory tests are medically necessary immediately or sooner than the normal return time for the Horizon BCBSNJ's network clinical laboratory; or b) accurate test results need to be determined by closely supervised procedures in venipuncture and laboratory techniques in controlled environments that cannot be achieved by Horizon BCBSNJ's network clinical laboratory.

Horizon BCBSNJ will pay the Hospital's clinical laboratory for the laboratory services at the same rate Horizon BCBSNJ would pay a Network clinical laboratory for comparable services.

Ambulance Charges
Horizon BCBSNJ covers Medically Necessary and Appropriate charges for transporting a Covered Person to:

a) a local Hospital if needed care and treatment can be provided by a local Hospital;
b) the nearest Hospital where needed care and treatment can be given, if a local Hospital cannot provide such care and treatment. But it must be connected with an Inpatient confinement; or
c) transporting a Covered Person to another Inpatient health care Facility.

It can be by professional Ambulance service, train or plane. But Horizon BCBSNJ does not pay for chartered air flights. And Horizon BCBSNJ will not pay for other travel or communication expenses of patients, Practitioners, Nurses or family members.

Durable Medical Equipment
Subject to Horizon BCBSNJ's Pre-Approval. Horizon BCBSNJ covers charges for the rental of Durable Medical Equipment needed for therapeutic use. At Horizon BCBSNJ's option, and with Horizon BCBSNJ's Pre-Approval, Horizon BCBSNJ may cover the purchase of such items when it is less costly and more practical than rental. But Horizon BCBSNJ does not pay for:

a) replacements or repairs; or

b) the rental or purchase of items such as air conditioners, exercise equipment, saunas and air humidifiers which do not fully meet the definition of Durable Medical Equipment.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for Durable Medical Equipment which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Orthotic or Prosthetic Appliances
We pay benefits for Covered Charges incurred in obtaining an Orthotic Appliance or a Prosthetic Appliance if the Covered Person's Practitioner determines the appliance is medically necessary. The deductible, coinsurance or copayment as applicable to a non-specialist physician visit for treatment of an Illness or Injury will apply to the Orthotic Appliance or Prosthetic Appliance.

The Orthotic Appliance or Prosthetic Appliance may be obtained from any licensed orthotist or prosthetist or any certified pedorthist.

Benefits for the appliances will be provided to the same extent as other Covered Charges under the Policy.

Treatment of Wilm's Tumor
Horizon BCBSNJ pays benefits for Covered Charges incurred for the treatment of Wilm's tumor in a Covered Person. Horizon BCBSNJ treats such charges the same way Horizon BCBSNJ treats Covered Charges for any other Illness. Treatment can include, but is not limited to, autologous bone marrow transplants when standard chemotherapy treatment is unsuccessful. Horizon BCBSNJ pays benefits for this treatment even if it is deemed Experimental or Investigational. What Horizon BCBSNJ pays is based on all of the terms of this Policy.

Nutritional Counseling
Subject to Horizon BCBSNJ Pre-Approval, Horizon BCBSNJ covers charges for nutritional counseling for the management of disease entities which have a specific diagnostic criteria that can be verified. The nutritional counseling must be prescribed by a Practitioner, and provided by a Practitioner.

Horizon BCBSNJ will reduce benefits by 50% with respect to charges for Nutritional Counseling which are not Pre-Approved by Horizon BCBSNJ provided that benefits would otherwise be payable under this Policy.

Food and Food Products for Inherited Metabolic Diseases
Horizon BCBSNJ covers charges incurred for the therapeutic treatment of inherited metabolic diseases, including the purchase of medical foods (enteral formula) and low protein modified food products as determined to be medically necessary by the Covered Person's Practitioner.

For the purpose of this benefit:

"inherited metabolic disease" means a disease caused by an inherited abnormality of body chemistry for which testing is mandated by law;"
low protein modified food product" means a food product that is specially formulated to have less than one gram of protein per serving and is intended to be used under the direction of a Practitioner for the dietary treatment of an inherited metabolic disease, but does not include a natural food that is naturally low in protein; and